**STATE OF TENNESSEE**
**DIVISION OF MENTAL RETARDATION SERVICES GENERAL COUNSEL**
**THIRTEENTH FLOOR ANDREW JACKSON BUILDING**
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# CONSERVATORSHIP INFORMATION FORM

PLEASE PRINT LEGIBLY

**INFORMATION OF PERSON COMPLETING THIS FORM: (IT WILL BE NECESSARY FOR YOU TO ATTEND ALL COURT PROCEEDINGS)**

Date: _____

Your Name: _____ Your Title: _____

Your Address: _____ Your Phone: (___) _____

_____ Alternate #: (___) _____

Zip Code: _____ Your Fax: (___) _____

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**INFORMATION OF DISABLED PERSON:**

Full Name: _____ SSN: _____

Level of Retardation: _____ DOB: _____

Secondary Diagnosis: _____ Sex: Male Female (Circle one)

_____

Other disabling conditions: _____

_____

_____

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**WHERE DOES THE DISABLED PERSON RESIDE (Provide complete address and phone number):**

***If** disabled person resides in a facility please complete the following:*

Name of Facility: _____ Building Name: _____

Phone # of Facility: (___) _____ County: _____

Facility Director's Name: _____ Director's Phone: (___) _____

*If disabled person lives at home, please complete the following:*

Home Address: _____ Person in most frequent contact with disabled
_____ Person:
_____ Name: _____

Zip Code/County: _____ Phone: _____

**PLEASE LIST THE DISABLED INDIVIDUAL'S CLOSEST LIVING RELATIVES:**
**(***Aunts, uncles, and cousins do not need to be listed, unless they are the closest living relative or unless the closest relatives' address and/or phone number is unavailable*.)

Name & Address: _____

_____ Phone: (___) _____

Name & Address: _____

_____ Phone: (___) _____

Name & Address: _____

_____ Phone: (___) _____

Name & Address: _____

_____ Phone: (___) _____

(*If you have names and addresses of additional family members, please attach a sheet with this form.)*

***∑ Please include dates of efforts to contact family members regarding their willingness and ability to serve as conservator.***

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**PROPOSED CONSERVATOR(S)**

Name: _____ SSN: _____
(Full Name)
DOB: _____

Mailing Address: _____ Relationship: _____

_____ Phone: (___) _____

_____ Work: (___) _____

***If the proposed conservator is not the closest relative, explain why the closest relative is not recommended:*** _____

_____

***PROPOSED STANDBY CONSERVATOR(S):***

Name of : _____
(Full Name)
SSN: _____
DOB: _____

Mailing Address: _____ Relationship: _____

_____ Phone: (___) _____

_____ Work: (  ) _____

## CURRENT CONSERVATOR

***PLEASE NOTE: If the disabled individual has ever had a court-appointed conservator, please attach a copy of the appointment order:***

Appointment Order Number: _____

Date signed by the Judge: _____

**Explain why the previous / current conservator needs to be replaced:** _____

_____

_____

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## REMOVAL OF RIGHTS

***Place a check by all the recommended <u>rights to be removed</u> from the disabled individual and entrusted to the Conservator:***

_____ To acquire or dispose of property

_____ To make purchases above $30.00

_____ To make purchases of any amount

_____ To execute instruments and/or contracts or enter into any other contractual relationship

_____ To give or withhold consent to medical and mental examinations, hospitalization, treatment and therapeutic or habilitative services or programs

_____ To make other health care decisions

_____ To give or withhold consent to custodial arrangements

_____ To file or pursue litigation in vindication of rights

## DISABLED INDIVIDUAL'S FINANCIAL DATA

Monthly Income: _____

Source of Income: _____

Current Account Balance: _____